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Mental Health Care Utilization in
VHA Community Based Outpatient Clinics
FY98-03
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Executive Summary

Community Based Outpatient Clinics (CBOCs) are currently required to provide mental health treatment except by documented exception. As an initial assessment of the level of mental health care in CBOCs, SMITREC published “Mental Health Care Utilization in VHA Community Based Outpatient Clinics, FY98-FY00” in June 2001. This report used the Outpatient Care File (OPC) visit files at Austin measure the incidence of mental health stop codes (500 series) and found a striking lack of mental health care being provided.

In order to elaborate upon the initial report, another report was written in March, 2002 which examined the OPC diagnosis files. The approach allowed for the inclusion of mental health care (as indicated by a primary psychiatric diagnosis), provided in non-mental health stop codes, as well as a picture of which diagnoses are being treated in the CBOC setting. Together, the two reports provided a comprehensive view of mental health treatment in CBOCs, both from the perspective of treatment providers in the form of stop codes and mental health diagnoses. Significant findings included a decline over time in the percentage of all stops which were for mental health, an increase in the percent of CBOCs with no mental health stops and 14% of mental health care being provided by non-mental health professionals in 2001.

In addition, for FY02 appropriations, Sections 1706 and 1720A of the Department of Defense Appropriations Act, Access to Mental Health Services, were amended by the addition of the following subsections: “The Secretary shall ensure that each primary care health care facility of the Department develops and carries out a plan to provide mental health services, either through referral or direct provision of services, to veterans who require such services.” and “The Secretary shall ensure that each medical center of the Department develops and carries out a plan to provide treatment for substance use disorders, either through referral or direct provision of services, to veterans who require such treatment. Each plan...shall make available clinically proven substance abuse treatment methods, including opioid substitution therapy, to veterans with respect to whom a qualified medical professional has determined such treatment methods to be appropriate.”

The current analyses use FY03 data to update the extent of MH stops at CBOCs, the presence of specialty MH care in CBOCs and their parent stations for specific diagnostic groups, and the growth in Category 7 veterans of CBOCs and their parent stations.

Major Findings

- In all major diagnostic groups (Substance Abuse, Psychosis, Major Depression, PTSD and Other) at least 23% of CBOCs nationally provided no specialty care in FY03. (*Figures 7, 9, 11, 13, 15*) This percentage remained high (at least 18%) when all CBOCs with fewer than 1500 unique patients treated were removed from the calculation.
- Those CBOCs that provided no MH specialty care were also much less likely to provide a primary diagnosis of mental health, with only 7.18% of veterans in those clinics without MH specialty care available receiving mental health diagnoses in clinics serving over 1500 uniques, compared to 18.14% in those CBOCs that have at least 5% of their visits in MH stops (Chi Square= $p < .00005$).
- The percentage of patients with primary psychiatric diagnoses who received at least one MH stop (i.e. specialized care) was essentially the same for CBOCs and their parent stations. The only exception was for Substance Abuse where a larger percent received this care at parent stations than at CBOCs (68% vs. 45%). (*Figure 4*)
- For all diagnostic groups, there was a large disparity between VISNs in terms of the percentage of CBOCs that provided at least 80% of their MH patients with at least one MH clinic stop in FY03. Eighty percent was used as a surrogate definition of CBOCs that provided “full” mental health coverage. (*Figures 8, 10, 12, 14, 16*)

- Only 7% of CBOCs nationwide provided at least 80% of their substance abuse patients with specialized MH care. (*Figure 7*) This percentage remained the same after CBOCs with fewer than 1500 uniques were removed from the calculations.
- Between FY98 and FY03 there was a much sharper increase in Category 7 veterans at CBOCs than at parent stations. (*Figure 17*) This differential increase was also found when only large (at least 1500 uniques) were included in the calculation. During this same time period, there was a general decline in MH services offered at CBOCs. (*Figure 1*)
- Between FY98 and FY03, the percentage of veterans seen in CBOCs who received any MH care fell in 15 VISNs, with an average drop of 7.29%. (*Figure 1*)
- In FY03, the percentage of MH patients in CBOCs receiving any specialty MH care varied by diagnostic group, from 94% for those with major depression to 45% for patients with substance abuse. (*Figures 7, 9, 11, 13, 15*)
- Despite the increasing emphasis on provision of MH care in CBOCs, between FY98 and FY03, the percentage of MH patients receiving specialized care dropped for substance abuse, psychosis and other MH diagnoses. (*Figure 3*)
- Between FY02 and FY03, at the national level, the percent of CBOCs which provided at least 80% of MH patients with at least one MH stop, rose for depression and PTSD but dropped for Other MH dx (from 23% to 11%) and for Substance Abuse (from 8% to 7%).
- For six variables that were reported at the VISN level (% of CBOCs with at least 80% of patients receiving specialty care in each of the five diagnostic groups and percentage of all CBOCs patients who received a MH stop in FY03) the following VISNs were noteworthy in their presence among the top and bottom three VISNs (up to 6 VISNs were included when equivalent scores were obtained):
 - VISN 10: top three, 6 times
 - VISN 2: top three, 5 times
 - VISN 6: top three, 3 times
 - VISN 9: bottom three, 6 times
 - VISN 22: bottom three, 4 times
 - VISNs 23: bottom three, 3 times
 - VISNs 4, 17 and 18: bottom three, 2 times

Recommendations

- Results of this report should be widely distributed to people in a position to make decisions re: allocation of resources for MH care in CBOCs.
- Plans to implement MH access in CBOCs should be continued.
- The goal of CBOCs is to improve access to care for veterans and it is imperative that veterans with mental illness, designated as a high priority group, receive the care they need in an equitable fashion.
- The proposed Performance Measure, Substance Abuse Treatment Initiation, should be adopted. It assesses whether a VA patient receives specialty substance abuse treatment within 14 days of being newly diagnosed with a SUD. This measure is in line with what will be required by HEDIS in 2004 and will thus allow VHA to benchmark their results. A corollary to this, specifically those patients who receive the care within 30 days, should also be collected for information purposes.
- The provision of mental health and substance abuse care in CBOCs should continue to be monitored to ensure that there is no further erosion of services.
- The low rates of primary MH diagnoses in those clinics without MH specialty staff suggest the possibility of under detection of mental illness. Under detection would artificially lower the denominator used in the calculation of specialty care, thereby leading to its overestimation. This deserves further exploration.

Background

VHA continues to place a great emphasis on moving patients from inpatient to outpatient care. Congress has mandated, however, that VHA maintain its capacity to treat the most vulnerable patients, including veterans with serious mental illness. Community Based Outpatient Clinics (CBOCs) have played a crucial role in providing this access to care. In its FY96 annual report, the Committee on the Care of Severely Chronically Mentally Ill Veterans noted that less than 40% of all CBOCs then offered any level of mental health services. The SMI Committee urged that all CBOCs be evaluated for the inclusion of mental health services, and that the lack of such services be allowed only by documented exception. The Undersecretary for Health concurred and a policy was issued directing such evaluations. In its 2002 report to Congress, the SMI Committee again noted the lack of adequate progress in this area and recommended that “The Undersecretary should assure that adequate funds are available, in each Network, to implement plans for the deployment of mental health services for high priority mentally ill veterans in Community-Based Outpatient Clinics (CBOCs)”. It also recommended that performance measures be developed to monitor mental health services in CBOCs and that Networks not meeting minimum standards on quarterly reviews be required to establish active, monitored plans to meet such standards.

As an initial assessment of the level of mental health care in CBOCs, SMITREC published “Mental Health Care Utilization in VHA Community Based Outpatient Clinics, FY98-FY00” in June 2001. This report used the Outpatient Care File (OPC) visit files at Austin measure the incidence of mental health stop codes (500 series) and found a striking lack of mental health care being provided.

In order to elaborate upon the initial report, another report was written in March, 2002 which examined the OPC diagnosis files. The approach allowed for the inclusion of mental health care provided in non-mental health stop codes (as indicated by a primary psychiatric diagnosis), as well as a picture of which diagnoses are being treated in the CBOC setting. Together, the two reports provided a comprehensive view of mental health treatment in CBOCs, both from the perspective of treatment providers in the form of stop codes and mental health diagnoses.

Significant findings included a decline over time of the percentage of all stops which were for mental health and substance abuse, an increase in the percent of CBOCs with no mental health stops, and 14% of mental health care being provided by non-mental health professionals in 2001.

In light of the above, SMITREC recommended that each Network submit a plan to the Chief Network Officer detailing plans to improve access to mental health services at CBOCs. In a memorandum from the Assistant Deputy Undersecretary for Health in August 2001, VISNs were asked to submit a plan to address access to mental health care in CBOCs. They were told that this plan should speak to the ability to provide “medication management and general counseling or psychotherapy services” and “convenient access to mental health care.”

In response to this mandate, all VISNs submitted a plan. To quote William Van Stone, Associate Chief for Psychiatry, Mental Health Strategic Healthcare Group, “All VISNs have approved plans to add or expand primary mental health services in their CBOCs. Converting those plans to action requires a decision at the facility and VISN levels to do so, based on local needs and funding priorities.” EES programs and tool kits have also been developed to help facilities and VISNs implement mental health care in all CBOCs, especially the use of telemental health. Plans are also being developed to separately track mental health care in small, medium and large CBOCs. A follow-up study is currently being considered.

In addition, for FY02 appropriations, Sections 1706 and 1720A of the Department of Defense Appropriations Act, Access to Mental Health Services, were amended by the addition of the following subsections: “The Secretary shall ensure that each primary care health care facility of the Department develops and carries out a plan to provide mental health services, either through referral or direct provision of services, to veterans who require such services.” and “The Secretary shall ensure that each medical center of the Department develops and carries out a

plan to provide treatment for substance use disorders, either through referral or direct provision of services, to veterans who require such treatment. Each plan...shall make available clinically proven substance abuse treatment methods, including opioid substitution therapy, to veterans with respect to whom a qualified medical professional has determined such treatment methods to be appropriate.”

To continue to monitor the presence of mental health care in CBOCs, SMITREC has completed these current analyses. They update the presence of MH stops at CBOCs, the presence of specialty MH care in CBOCs for specific diagnostic groups, and track the growth in numbers of Category 7 veterans in CBOCs and their parent stations through FY03.

Methods

Station numbers were obtained from AAC for FY 98, 99, 00, 01, and 02. This list of CBOCs was then reviewed to determine which CBOCs should be the primary focus of this report. As a result, CBOCs were excluded from this report if one or more of the following statements were true: 1) the CBOC provided 80% or more mental health care based on the number of mental health stops over the number of global stops for FY02; or 2) the CBOC had less than 12 outpatient visits during FY 02. For any given fiscal year's data, a CBOC was excluded if it had been open for less than one year. The first group was excluded because it did not reflect a setting of primary medical care, and the second was excluded because they were not in operation in FY02.

After a presentation to the SCMI Committee in January, 2004, a decision was made to add FY03 data to make the report more timely. Newly opened CBOCs and the FY03 data for all CBOCs included in the previous version of the report were added but the exclusion criteria were not applied using the FY03 data. The implications of this are that there may be CBOCs included or excluded in this report that would not have been had the exclusion criteria been based on the FY03 data.

Patient level data were pulled from the OPC encounter/event files at AAC for the 6 years mentioned above. These files were created in an effort to join diagnosis information with clinic stop information in order to provide a better picture of a veteran's encounter in the VA Healthcare System. All data were collected at the CBOC level so veterans who moved around in the system are counted at each CBOC in which they received care.

In order to provide some assurance that the data presented in this report are sound, VISN 16 compared our findings with data previously collected. The VISN 16 data were consistent with the data presented here.

Mental health diagnoses were grouped according to the following parameters:

Psychosis includes all schizophrenic disorders (295) other than latent schizophrenia (295.5), manic disorder, single episode (296.0), manic disorder, recurrent episode (296.1), bipolar affective disorder, manic (296.4), bipolar affective disorder, depressed (296.5), bipolar affective disorder, mixed (296.6), bipolar affective disorder, unspecified (296.7), manic-depressive psychosis, other and unspecified (296.8), paranoid states (297) and other non-organic psychoses (298).

PTSD includes prolonged post traumatic stress disorder (309.81).

Substance abuse includes alcoholic psychoses (291), drug psychoses (292), alcohol dependence syndrome (303), drug dependence (304), and nondependent abuse of drugs (305).

Major depression includes major depressive disorder, single episode (296.2), major depressive disorder, recurrent episode (296.3).

Other MH dx includes all ICD-9 codes, 290-318, not listed above.

We counted mental health stops as any 500 series stop code. When looking at a specific mental health diagnosis, our primary concern was whether or not veterans received ANY specialized mental health care. The specific stop code was not the focus of our study and we did not compare the nature of the mental health stop to the primary mental health diagnosis of the veterans.

To determine the percentage of Category 7 veterans at CBOCs and parent stations, counts of unique veterans at all facilities within the VA for FY98-03 were pulled from the encounter/event (SE) data files at AAC. The presence of a “C” in the means variable indicated that the veteran was a Category 7 patient.

Table 1 presents the percent of veterans seen in a CBOC who received any care in a mental health stop along with the total number of uniques seen in that CBOC. Its source is Patient Encounter/Event files at AAC and the information is presented at the station level for FY98-03.

Table 2 presents the same information as Table 1 at the VISN level.

Table 3 explores the availability of specialized mental health care and substance abuse at each individual CBOC by reporting the percent of patients with a **primary psychiatric diagnosis (indicating the reason for the visit) with any care at a mental health clinic stop at the same site**. Separate information is provided for substance abuse, major depression, psychosis, PTSD and other psychiatric diagnoses. The information is presented at the CBOC level for FY98-03.

Table 4 presents the same information as Table 3 at the VISN level.

Table 5 presents the relative percentage of Category 7 veterans at each CBOC and their parent facilities. The purpose of this table is to compare the volume of category 7 veterans coming into the system at the CBOCs and the volume of category 7 veterans seen at the parent station.

Table 6 compares the levels of specialized mental health care and substance abuse at CBOCs and at parent stations to determine if patients at CBOCs are receiving less of this type of care.

Findings

- In all diagnostic groups (Substance Abuse, Psychosis, Major Depression, PTSD and Other) at least 23% of CBOCs nationally provided no specialty care in FY03. (*Figures 7, 9, 11, 13, 15*) This percentage remained high (at least 18%) when all CBOCs with fewer than 1500 uniques were removed from the calculation.
- Those CBOCs that provided no MH specialty care were also much less likely to provide a primary diagnosis of mental health, with only 7.18% of veterans in those clinics without MH specialty care available receiving mental health diagnoses in clinics serving over 1500 uniques, compared to 18.14% in those CBOCs that have at least 5% of their visits in MH stops (Chi Square= $p < .00005$).
- The percentage of patients with primary psychiatric diagnoses who received at least one MH stop (i.e. specialized care) was essentially the same for CBOCs and their parent stations. The only exception was for Substance Abuse, where a larger percent received this care at parent stations than at CBOCs (68% vs. 45%). (*Figure 4*)
- For all diagnostic groups, there was a large disparity between VISNs in terms of the percentage of CBOCs that provided at least 80% of their MH patients with at least one MH clinic stop in FY03. Eighty percent was used as a surrogate definition of CBOCs that provided “full” mental health coverage. (*Figures 8, 10, 12, 14, 16*)
- Only 7% of CBOCs nationwide provided at least 80% of their substance abuse patients with specialized MH care. (*Figure 7*) This percentage remained the same after all CBOCs with fewer than 1500 uniques were removed from the calculations.

- 37% of CBOCs nationwide provided specialty care in a CBOC to at least 80% of their patients with psychosis. This rose to 47% for patients with schizophrenia only (48% of all patients with psychosis).
- The national average of patients with primary diagnosis of schizophrenia seen in a MH stop is 88% as opposed to 81% for patients with any psychosis.
- Between FY98 and FY03 there was a much sharper increase in Category 7 veterans at CBOCs than at parent stations. (*Figure 17*) This difference pertained when only large (at least 1500 uniques) were included in the calculation. During this same time period, there has been a general decline in MH services offered at CBOCs.
- Between FY98 and FY03, the percentage of veterans seen in CBOCs who received any MH care fell in 15 VISNs, with an average drop of 7.29%. (*Figure 1*) Between FY02 and FY03, it fell in 9 VISNs (average drop of 1.16%).
- In FY03, the percentage of MH patients receiving any specialty care varied by diagnostic group, from 94% for patients with major depression to 45% for patients with substance abuse. (*Figures 7, 9, 11, 13, 15*)
- Despite the increasing emphasis on provision of MH care in CBOCs, between FY98 and FY03, the percentage of MH patients receiving specialized care dropped for substance abuse, psychosis and other MH dx. (*Figure 3*)
- Between FY02 and FY03, at the national level, the percentage of CBOCs that provided at least 80% of MH patients with at least one MH stop, rose for depression and PTSD but dropped for Other MH dx (from 23% to 11%) and for Substance Abuse (from 8% to 7%).
- For six variables which were reported at the VISN level (% of CBOCs with at least 80% of patients receiving specialty care in each of the five diagnostic groups and percentage of all CBOCs patients who received a MH stop in FY03) the following VISNs were noteworthy in their presence among the top and bottom three VISNs (up to 6 VISNs were included when equivalent scores were obtained):
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Recommendations

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